CSHCS WEB PORTAL
WEB PORTAL ENROLLMENT & CHANGE REQUEST FORM ***(TEST FORM)***
State Form #####
Indiana State Department of Health

Children's Special Health Care Services Program (*CSHCS*) offers a WEB Application for Providers to perform certain functions as it pertains to the Eligibility and Claims of the covered participants of the CSHCS Program via a secured WEB Portal.

To obtain a login to the CSHCS WEB Portal, this Enrollment Form must be completed in full and returned to:

Indiana State Department of Health
Attention: OHC/EDI Department
2 N. Meridian Street, 3K
Indianapolis, IN 46204
Fax: 317-233-8199
Phone: 317-233-9803

Enrollment Type:
Please select one: Provider: ☐ Billing Company: ☐ Other: ☐

Instructions:

- For changes to existing accounts, the user with administrative rights should complete section 1 and check the Change Request box. Enter any changes to your account in the appropriate section(*s*) below.
- For new enrollments, please follow instructions below:

Providers:

Please complete sections 1, 2, 3, & 4. Return to the address indicated above or send via fax.

Billing Companies:

Please complete sections 1, 2, & 4 only. Return to the address indicated above or send via fax.

Other:

Please complete sections 1, 2, & 4 only. Return to the address indicated above or send via fax.

Once your completed form has been received and verified, your login will be established and sent to each individual via e-mail with instructions for login and setting your password.

1. Demographic Information: **New Request: ☐** **Change Request: ☐**

Name: _____

Tax ID#: _____-_____ (*Providers Only*)

Service Location
Street Address: _____

City: _____ State: _____ Zip: _____ -_____

Contact Name: _____

Telephone: ____/_____-_____ E-mail: _____

2. Logins:

- Access to the CSHCS WEB Portal is limited to one session per login at a time. It may be necessary for a provider or billing office to have more than one login if multiple accesses are needed at the same time. Logins will be assigned per individual.

 # Of Logins Requested (*up to 8*): _____

Names of Individuals to be granted access; please print clearly:

Primary Login (*will have administrative rights*)

Login Type	Last Name	First Name, MI	Telephone #	Email Address	Effective Date	Term Date
Primary w/Admin Rights						
Additional 1						
Additional 2						
Additional 3						
Additional 4						
Additional 5						
Additional 6						
Additional 7						

- **Providers Only:** For Privacy each Login is granted access to view claim information for claims rendered by the provider of service who is tied to that login. This is controlled by Provider's NPI Number. Because some Providers Offices have more than one NPI, please list below all NPI's that the requested logins should have access to.

NPI #: _____ NPI #: _____

NPI #: _____ NPI #: _____

NPI #: _____ NPI #: _____

NPI #: _____ NPI #: _____

3. Additional Access (*For Providers Only*): New Request: ☐ Change Request: ☐

- **Do you use an outside Billing Company? Yes: _____ No: _____**
- ***If yes,*** do you want the Billing Company to have on-line access to your claim information? **Yes: _____ No: _____**
- ***If yes,*** the below information is required to establish login access for the Billing Company:

Billing Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ -_____

Contact Name: _____

Telephone: ____/_____-_____ E-mail: _____

Date Terminated: ___/___/___ (Billing company will no longer have access to your patient's claim information)

- Please list the NPI numbers that the Billing Company is authorized to view claims history for:

NPI #: _____ NPI #: _____

NPI #: _____ NPI #: _____

NPI #: _____ NPI #: _____

NPI #: _____ NPI #: _____

- **The provider should advise the billing company to contact our office at the phone number on the front of this form. The Billing Company will not have access unless they contact our office directly.**

4. Authorization:

PLEASE NOTE: IT IS THE RESPONSIBILITY OF EACH PROVIDER TO NOTIFY CSHCS WHEN ITS RELATIONSHIP WITH AN EMPLOYEE OR BILLING COMPANY IS TERMINATED. SUCH NOTIFICATION SHOULD BE SENT USING THE ONLINE LOGIN TERMINATION FUNCTION OR BY COMPLETING AND SENDING THE CHANGE REQUEST INFORMATION ON THIS FORM AS SOON AS POSSIBLE.

By signing below you agree that above information is correct and that if any changes occur in the above information, a new Provider WEB Portal Application Enrollment Request Form (Change Request) will need to be completed with the updated information.

Authorized Representative's Signature: _____

Authorized Representative's Title: _____

Authorized Representative's Telephone #: _____/_____-_____X_____

Authorized Representative's E-mail: _____

Date Signed: _____/_____/_____